Michigan Department of Labor & Economic Growth

INJURY AND ILLNESS INCIDENT REPORT

Michigan Department of Labor and Economic Growth
Michigan Occupational Safety and Health Administration (MIOSHA)
Form Approved OMB No. 1218-0176

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. You may be fined for failure to comply.

If you need additional copies of this form, you may photocopy and use as many as you need.

COMPLETED BY

TITLE

PHONE ( )

DATE / /

Information about the employee

1. FULL NAME

2. STREET

CITY | STATE | ZIP CODE

3. DATE OF BIRTH / /

4. DATE HIRED / /

5. ☐ MALE ☐ FEMALE

Information about the physician or other health care professional

6. NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL

7. IF TREATMENT WAS GIVEN AWAY FROM THE WORKSITE, WHERE WAS IT GIVEN?

FACILITY

STREET

CITY | STATE | ZIP CODE

8. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?
☐ YES ☐ NO

9. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT?
☐ YES ☐ NO

Information about the cases

10. CASE NUMBER FROM THE LOG (Transfer the case number from the Log after you record the case.)

11. DATE OF INJURY OR ILLNESS / /

12. TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

13. TIME OF EVENT ☐ AM ☐ PM ☐ Check if time cannot be determined

14. *WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?*
Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "Climbing a ladder while carrying roofing materials"; "Spraying chlorine from hand sprayer"; "Daily computer key-entry."

15. *WHAT HAPPENED?*
Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

16. *WHAT WAS THE INJURY OR ILLNESS?*
Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," "sore." *Examples:* "Strained Back"; "Chemical Burn on Hand"; "Carpal Tunnel Syndrome."

17. *WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?*
Examples: "Concrete Floor"; "Chlorine"; "Radial Arm Saw." If this question does not apply to the incident, leave it blank.

18. *IF THE EMPLOYEE DIED, WHEN DID DEATH OCCUR?*
DATE OF DEATH / /

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